CAPTA Call
TECHNICAL ASSISTANCE FOR CAP GRANTEES

Grantees interested in participating in training workshops and follow-up onsite help may contact Audrey Smolkin (asmolkin@hrsa.gov) for referrals and further information.

March 5, 2002

CASE MANAGEMENT

CAP grantees participated in a Technical Assistance call on March 5, 2002 that featured leaders from six different communities offering their experience with case management procedures. Each of the speakers had unique stories to share with the group.

SKYCAP (Southeast Kentucky Community Access Program)

Fran Feltner, director of the SKYCAP program and employee of the University of Kentucky Center for Rural Health (UKCRH), spoke to grantees about the case management program at SKYCAP, and offered her advice for others attempting to provide similar services. SKYCAP employs lay health workers known as Family Health Navigators (FHNs) to conduct case and disease management activities. Case management and disease management are combined into one model, focusing specifically on five primary diseases: asthma, diabetes, heart disease, mental illness, and hypertension.

FHNs are required to have a high school diploma, are trained by SKYCAP prior to employment, and are supervised by an RN, LPN team leader, physicians, and other providers in the community. They provide total holistic health care services to their clients. They monitor clients' immediate health concerns as well as their educational, social, and emotional needs. FHNs perform the following specific services:

- They conduct comprehensive home visits that include assessments of the client's and the family's needs for physical health, mental health and social services. They then provide information and education about available services, and how to access providers.
- They act as a liaison between clients and their families, and service providers, and report anything that may impede clients from obtaining available services.
- They work with multi-disciplinary teams to establish action plans for clients and families and ensure that the plans are carried out.
- They link clients with related services and support groups, and provide emotional and educational support for clients and their families when appropriate.

FHNs serve as the primary health care contact for patients in need, helping to keep them focused when they're visiting multiple providers or specialists. The FHN is the one person a client can turn to at any time for any health care or social needs.

SKYCAP's case management program relies on its customized management information system (MIS). The system tracks clients in real time and provides a comprehensive medical records database. Case managers and physicians use the system to track client health status and activities. Fifty community-based facilities refer to the program as well as provide services. Eleven sites are directly connected to the system. Use of the system has significantly reduced duplication of services and unnecessary emergency department and hospital visits.

Ms. Feltner had the following recommendations for communities in the process of establishing case management programs:

- Assess what your organization defines as case management. What is your definition of case management vs. disease management? Will you combine the two?

- Determine the key players on your case management team early on. Will they be physicians, social workers, or both? Identify your providers and determine who will act as case managers.

- Identify your target population. If you have 6,000 individuals, how will you prioritize? Decide on your target population and any diseases you will focus on before you get started. Establish standard parameters and benchmarks.

- Empower your clients to self-manage. Encourage them to be active participants in their own health care. Ask what kinds of services they need, and what kind of educational materials they're interested in.

- Track your patients attentively. Are they taking the right medications? Are they attending their scheduled appointments?

- Get family support for the patient whenever possible.

- Conduct peer reviews to ensure that patients are receiving the care they need.

- Consider developing a comprehensive MIS that will help case managers and providers communicate and track patients' care and progress.

Jackson Medical Mall Foundation/Hinds County Health Alliance (HCHA)

Fleetwood Loustalot, CFNP, Director of Case Management for the Hinds County Health Alliance (HCHA), spoke to grantees about the current program offered through the HCHA and the Jackson Medical Mall Foundation. Jackson Medical Mall is a former shopping mall that has been converted into converted into a facility with multiple medical clinics, research programs, local university program extensions, and retail stores. HCHA serves the community at Mall facilities and other clinics located throughout the community.

HCHA distributes authorization forms and educational materials for its services to the four major hospital systems in Jackson, Mississippi. Caseworkers (Case Managers, Social Workers, etc.) at each hospital determine which patients need HCHA services. Patients complete the appropriate forms and then Caseworkers make referrals based

on prior participation with a PCP or general location of residency. The Caseworkers send the referrals to HCHA clinics and schedule initial follow-up appointments. Caseworkers at the hospitals also send the authorization forms to HCHA for enrollment into the HCHA database. HCHA case managers then contact patients to establish relationships and determine need for further services such as transportation, eligibility determination follow-up, medication assistance, case management/disease management participation, or other services.

Patients are offered three primary services through HCHA's case management program:

1. *Public Program Enrollment*: Case managers conduct eligibility screenings to determine if patients are eligible for public programs such as CHIP, Medicaid, Medicare, etc.

2. *Transportation Program*: HCHA hired a dispatcher and established a phone number for patients to call to receive public transportation information. The dispatcher reviews all available methods of public transport and refers the patient to the best choice.

3. *Medication Program*: HCHA has several pharmacies located within its clinics in various locations. A tiered approach is used for each patient:

    - *First option*: Obtain medications free of charge through local pharmaceutical company programs.

    - *Second option*: Obtain discounted medications via the 340B Drug Program.

    - *Third option*: Obtain discounted medications via manufacturers' Pharmaceutical Assistance Programs (PAPs). HCHA has been successful using the RxAssist program for PAPs, and is currently in the process of switching to MedData. Mr. Loustalot believed both programs are very helpful.

In addition to these programs, HCHA also offers two additional innovative projects as part of its case management system:

1. *Cellular phone distribution*: HCHA has established a relationship with a local telecommunications firm to obtain cellular phones at a significantly discounted rate. Cell phones are pre-programmed to make outgoing calls only to specified locations such as the pharmacy, clinic, transportation services, or case manager. Users can receive unlimited incoming calls free of charge. This service provides an essential communication link for patients who lack telephone access. Phones are only distributed to high-risk clients.

2. *State-of-the-Art Kiosks:* HCHA has placed medical kiosks in multiple locations in Jackson Medical Mall and in service areas (such as grocery stores) located in outlying rural areas. Kiosks are used to monitor and record patient blood pressure, pulse, and weight, and send this information via the Internet to an online database used by physicians. The kiosks will eventually send this information directly to respective provider offices.

Mr. Loustalot explained one of the keys to the success of HCHA's case management program is its relationship with the local hospital systems and clinics. All four major hospital systems refer all of their uninsured patients to HCHA for care.

HealthAssist of Greenville, North Carolina

Michelle Sawyer, Administrator for Regional Health Plans at University Health Systems of Eastern Carolina, joined the call to discuss the details of her collaborative's case management program. HealthAssist is an expansion of an existing Medicaid Managed Care Program. The goal of HealthAssist is to help increase the enrollment of patients into the Medicaid program as well as to expand services available to uninsured individuals who do not qualify for Medicaid or Medicare.

HealthAssist has four major components:

1. Medical care offered through a network of primary care physicians, specialists, health departments, hospitals, and other providers.

2. A medication assistance program that acquires discounted medications through manufacturer PAPs, private funds, and a strict formulary process.

3. Community Resource Centers established throughout the community that offer health education, screenings, case management, and a limited amount of clinical care.

4. Community-based case management services with a focus on disease management and service coordination.

HealthAssist's case managers are either nurses or social workers who maintain offices directly within the communities they serve. The case managers obtain patient information from participating primary care providers who have adopted HealthAssist's standard of care guidelines.

HealthAssist employs risk stratification procedures to determine which of their enrollees is in highest need for case management services. Disease condition, utilization of hospital and emergency department services, and disease management options are reviewed in the process of choosing patients who qualify for HealthAssist's services. Like other collaboratives, HealthAssist has merged its disease management and case management programs. The program's focus has been on patients with diabetes and asthma, but patients with cardiac conditions such as heart failure will begin to be added to the case management program this year.

A noticeable reduction in emergency department visits occurred following implementation of case management for Medicaid enrollees. The most remarkable differences were seen among patients with asthma and ambulatory care sensitive diseases (ACSDs). The expansion of this care management model to the uninsured is a primary focus of HealthAssist.

Broward County

Sharon Zucci, RN, Manager from the Memorial Healthcare System (MHS) in Broward County, Florida, spoke to grantees about Broward County's combined disease/case management program. Before receiving their CAP grant, MHS focused solely on case management. Additional support from CAP funding has enabled the collaborative to add comprehensive disease management to its existing program.

MHS defines its disease management program as "an integrated system of intervention, measurements, and refinements of healthcare delivery designed to optimize clinical and economic outcomes within a specific population." The program relies on aggressive prevention of complications and treatment of chronic conditions. It focuses on the positive impact of appropriate interventions in delaying morbidity and mortality among patients with diabetes, asthma, and HIV/AIDS. Patients are referred by three primary sources, including monthly hospital computer data that details visits by uninsured clients, a local "First Call For Help" referral line, and local physicians.

Nurse Disease Managers, who encourage face-to-face meetings with patients, act as their liaison among providers, scheduling appointments and monitoring compliance. Intervention and patient education are considered essential elements of the program, which incorporates appropriate educational tools, including relevant written materials and referrals to support groups and counseling, to encourage patients to clearly understand and manage their health care program.

Nurse Disease Managers use a three-step approach to ensure patient care:

1. *Assessing and Planning:* Nurses conduct an assessment of each patient's disease status and risk factors for complications, including patient history, results from a recent physical, and extensive lab work. The physician then works with the nurse manager to develop an appropriate health care plan.

2. *Implementation and Delivery:* Nurses conduct a follow-up assessment to determine the patient's physical condition, lab results, and self-monitoring results and analyze patient compliance with established disease-specific guidelines for care.

3. *Reassessment and Adjustment:* Patient progress is reassessed based on current information and adjustments to patient plans are made accordingly.

MHS uses multiple evaluation methods to measure progress and success rates. Patient quality of life surveys are conducted at the point of entry into the system and again six months after entry. Patient and provider satisfaction surveys are conducted yearly. Lab results and health care costs are also consistently monitored.

Access II Care

Christine Collins from Access II Care in Asheville, North Carolina discussed her program's case management services, which are currently offered to Medicaid patients diagnosed with asthma and diabetes and patients who have been identified as high cost and frequent users of health care services.

Access II Care's case management services are unique. Patients are assigned by the DMA (Division of Medical Assistance) to participating primary care providers (PCP) in a

network. Case managers are then assigned to participating practices and are often located onsite in the primary care offices. Case managers provide services in three areas:

1. *Population Management*: A disease registry is used to monitor every patient with a specific chronic disease. Chart reviews and limited outreach activities are conducted to ensure that each patient is receiving the care that they need through their PCP.

2. *Benefits Advocacy*: A one-time intervention is offered to patients to remove a barrier to care, provide necessary health education, or inform them of their rights and responsibilities.

3. *Case Management:* Case managers work with patients to address both their medical and psychosocial needs.

The key to Access II Care's success is provider participation. Providers are involved in the development of disease management services and case management standards. Facilitating participation can be a challenge. Access II Care focuses a significant amount of attention and energy on assisting practices in changing their practice patterns. The benefits of implementing in-house case managers are frequently documented and presented to providers. Ms. Collins had the following recommendations for other communities attempting to increase provider buy-in:

- *Partnership***:** Involve the physician in the decision-making process. Be open to their suggestions and allow for individualized adjustments.

- *Pride*: Most physicians pride themselves on providing good care. Find an example of something that is working well in their practice and call attention to it.

- *Responsibility*: Design a system that designates responsibilities for each member. Create a win-win situation. For example, ensure that case managers will ease the work load and find missing patients, and that the physician will adopt the same protocol for all patients.

- *Feedback*: Provide specific, accurate data, including claims and random chart audits.

- *Competition*: Share results from multiple providers in a non-threatening manner. This may encourage providers to equal or better their counterparts.

- *Recognition*: Acknowledge successful programs. Even minor recognition such as gifts of chocolate provide encouragement for diligent work to continue.

- *Provider Education*: Present important information to the provider in a convenient manner. Offering lunch provides a good ice breaker and allows time for discussion. Be sure to ask what the provider needs. Consider having a local expert deliver your message.

- *Champion*: Locate the champions in each practice who will support your mission. A successful program requires the involvement of the entire staff, not just the physician.

- *Simplicity*: Keep your message and program suggestions as simple as possible.

Lompoc Valley

Gail Nickerson from Lompoc Valley, California, joined the call to discuss the case management software program that her collaborative is currently using, Casewatch, a product of Automated Case Management Systems, Inc. Lompoc developed its own assessment tool, surveys, authorization forms and other forms that were integrated into the Casewatch program. The result is a community health information system that links hospitals, public health departments, care coordination offices, and other providers into one automated system. The collaborative has been very pleased with the system and is particularly satisfied with the technical support provided by the developer. Ms. Nickerson is available to discuss the program and its implementation in greater detail. Her contact information is listed below.

Program Sustainability

Dr. Jack Epstein, a Family Physician and champion of Disease Management protocols, presented ideas for designing disease and case management programs for sustainability. Dr. Epstein has experience as both an HMO and Health Center medical director and has facilitated disease/case management sessions at CAP grantee meetings. The Flint Group, Dr. Epstein's organization, is a health care consultancy that has authored a curriculum in disease management for the Bureau of Primary Health Care, and has worked with the clinician group that developed Evidence-Based Health Care guidelines for Health Centers.

Dr. Epstein noted that several factors determine whether a case or disease management program will prosper and continue after the grants stop. The single best predictor is the ease with which a case management program is implemented. If a particular program is difficult to initiate, it may signal underlying problems that will prevent the program from being successful in the long-term.

Dr. Epstein suggested the following questions to consider when designing a disease or case management program for sustainability:

- Who drives the program renewal decision?

- Is there a budget for the program? Is it adequate to support the program's objectives?

- Are there champions within the program and among the provider community who will drive the effort?

- Will local hospital and university partners support your program?

Effective case management program design should reflect thoughtful consideration of questions such as these. Dr. Epstein noted that the reasons programs continue beyond an initial grant period are related to either outcome or process measures. Measures to consider include:

Outcome Measures:

- *Cost Savings* - The case/disease management program demonstrates a noticeable savings that benefits the entire initiative.
- *Clinical Improvement* – The case/disease management program leads to enhanced clinical services and operations.
- *Patient Retention* – Patients continue to participate in the program as a direct result of the case/disease management feature.
- *Staff Retention* – Staff members are directly benefited by the existence of the case/disease management program.

Process Measures:

- The disease or case management program is recognized as an essential component of the entire initiative.
- The program is a valued resource and solutions provider.
- The program acts as a quality improvement auditor for an initiative.
- The program facilitates network building among key partners.

Dr. Epstein recommends that these concepts should be addressed even before the grant application is submitted. However, since many organizations do not consider renewal until a case/disease management program is already implemented and functional, Dr. Epstein emphasized enhancing for sustainability at the earliest possible opportunity.

Many case/disease management programs have the potential to become a permanent part of the care-giving process. A concise, credible story of achievement backed by process and outcome data should influence both internal and external directors of the program toward long-term sustainability. The key to program longevity is to consistently communicate its performance to the internal and external decision makers long before the program is due for renewal.

Conclusion

As demonstrated in this discussion, case and disease management programs vary considerably depending on the needs of the clients served. Currently, there are no set guidelines for establishing these programs. The CAP grantees who discussed their experiences provided valuable insight about how to approach, implement, and monitor these beneficial programs. For more information, please contact the call participants to learn more about case management and the specific programs that were discussed during this call.

For More Information

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